Nurse's Notes

Willis Knighton South

Name: Aaliyah [redacted]
Age: 4 yrs **Sex:** Female **DOB:** 10/01/2013
Arrival Date: 02/10/2018 **Time:** 01:54
Bed 20

MRN: 1116206
Account#: K20034594943
Private MD: Allen, Scott

Presentation:

02/10 02:05 Preferred language for medical communication is English. Presenting complaint: Mother states: woke up at midnight wheezing and coughing, i took her to quick care the other day, she has strep throat and URI, shes been taking a z pack, gave breathing treatment at home with no relief, pt currently sitting in tripod position. Person Transporting: Parent. Transition of care: patient was not received from another setting of care. Mechanism of Injury: denies injury. Care prior to arrival: Medications: Albuterol Neb. sr11

02:11 Acuity: 2 - Emergent. sr11

02:15 Method of Arrival: Ambulatory. sr11

Triage Assessment:

02:05 **General:** Appears well developed, well nourished, well groomed, distressed, uncomfortable, Behavior is appropriate for age, anxious, mobility; ambulates without assistance. **Pain:** level that is acceptable is 0 out of 10 on a pain scale. sr11

Historical:

- **Allergies:** Codeine; FISH PRODUCT DERIVATIVES;
- **Home Meds:**
  1. Albuterol Inhl as needed
  2. dulera 2 puffs am and 2 puffs pm
  3. Singulair PO nightly
- **PMHx:** Asthma; Autism
- **PSHx:** None

Historical:

02:11 Family history: No immediate family members are acutely ill. Immunization history: Childhood immunizations up to date, Last flu immunization: up to date. Social history: The patient lives at home with mother The patient attends nursery school the patient is a minor. sr11

02:33 The history from nurses notes was reviewed and confirmed. dre/mj2

Screening:

02:05 **Abuse screen:** sr11
Denies threats or abuse. Denies injuries from another. there are no obvious signs of child abuse.
Patient fall risk assessment;
No risks identified.
Learning Barriers:
No barriers to teaching and learning identified.
Pedi Fall Risk
No risks identified.
Exposure risk/Travel Screening:
No exposures identified.

Assessment:

02:11 **Pain:** Denies pain. level that is acceptable is 0 out of 10 on a pain scale. **General:** Appears well developed, well nourished, well groomed, distressed, uncomfortable, Behavior is appropriate for age, anxious, mobility; ambulates without assistance. **Neuro:** Level of Consciousness is alert, awake, obeys commands. **EENT:** Reports Sore Throat Parent/caregiver reports the patient having nasal congestion nasal discharge. **Cardiovascular:** Capillary refill < 3 seconds is brisk in bilateral fingers Rhythm is sinus tachycardia. **Respiratory:** Respiratory effort is labored, with retractions, using tripod position, Respiratory pattern is tachypnea Airway is patent Breath sounds with wheezes bilaterally. **Dermatologic:** Skin is intact, is healthy with good turgor, Skin is pink, warm & dry. normal. sr11

02:33 **Respiratory:** Reassessment: Patient states symptoms have improved. sr11

Vital Signs:

Time	B/P	Pulse	Resp	Temp	Pulse Ox	Weight	Height	Pain	Staff
02:05		156	36	99.3	91% on R/A	18.14 kg / 39 lbs 16 oz	3 ft. 2 in. (96.52 cm)		sr11
03:23		145	34		99%				sr11

02:05 Body Mass Index 19.47 (18.14 kg, 96.52 cm) sr11

EXHIBIT
tabbies
6